

Bureau of Health Care Quality and Compliance

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4993AGZ | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/04/2010 |
| NAME OF PROVIDER OR SUPPLIER NORTHWEST GROUP HOME | | STREET ADDRESS, CITY, STATE, ZIP CODE 4611 STARTRAIN DR NORTH LAS VEGAS, NV 89031 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| Y 000 | <p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 6/4/10. This complaint investigation was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for 6 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 6.</p> <p>Complaint #NV00025488 was substantiated. See Tag Y9999.</p> <p>The following deficiencies were identified:</p> | Y 000 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE